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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a partial extended complaint survey #88229. A revised 2567 was sent to the facility 8/5/15. | F 000 | | |
| F 323 SS=J | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 30 residents. Based on observation, interview, and record review the facility failed to provide supervision for 1 of 3 residents sampled for accidents (#2, a cognitively impaired independently mobile resident) failed to provide supervision to prevent resident #2 from exiting the facility without staff knowledge. This placed the Resident #2 in immediate jeopardy.<br><br>Findings included:<br><br>- The facility admitted resident #2 on 9/26/13 with diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), psychosis (any major mental disorder characterized by a gross impairment in reality testing), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and | F 323 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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secondary parkinsonism (slowly progressive neurologic disorder characterized by resting tremor, rolling the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).

The annual Minimum Data Set Assessment dated 1/21/15 documented the resident with a Brief Interview for Mental Status (BIMS) score of 00, which identified the resident with severe cognitive impairment. The resident wandered daily, experienced delusions, and required supervision of one staff for locomotion. The resident exhibited unsteady balance, only able to stabilize with staff assistance and experienced two or more non-injury and one minor injury fall since the previous assessment.

The Care Area Assessment (CAA) dated 1/31/15 for cognition documented the resident had poor short and long-term memory recall, poor safety awareness and a decreased ability to care for him/herself.

The CAA for falls dated 1/31/15 documented the resident with five falls since the previous assessment period. The resident wandered throughout facility in a wheelchair. A physical therapy referral December 2014 recorded the resident was unable to follow commands to participate in therapy at that time.

The CAA for behaviors dated 1/31/15 documented the resident wandered daily throughout the facility in a wheelchair and had a personal body alarm on at all times. The facility doors had alarms on at all times.

The quarterly Minimum Data Set Assessment dated 4/23/15 recorded the resident with a BIMS

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(Brief Interview for Mental Status) 2, which indicated severe cognitive impairment, exhibited physical behaviors towards others as well as other behaviors not directed at others and wandering behavior daily. The resident required extensive assist with activities of daily living, unsteady balance, only able to stabilize with staff assistance, used a wheelchair for locomotion, and experienced two or more non-injury falls since the previous assessment.

Review of the Elopement Risk Assessments dated 4/17/15 and 7/18/15, documented a score of (11) which indicated a total score of 11 or greater placed the resident at high risk to wander.

Review of the comprehensive care plan initiated 9/12/14 and reviewed 5/27/15 identified the resident was an elopement risk and wanderer related to a diagnosis of Alzheimer's disease, which affected his/her memory and leads to him/her wandering aimlessly. The resident was disoriented to place and had a history of attempting to leave the facility unattended. The care plan directed staff to:

*Redirect the resident when seeking to go through exit doors.
*Monitor the resident ' s location every 60 minutes. Document wandering behaviors in the wander log.
*Identify pattern of wandering. Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate.
An additional intervention added 6/13/15 documented staff replaced all pagers batteries with new ones and tested each one. Staff checked all doors for the sounding alarm.

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A nursing note dated 4/9/15 timed 4:56 A.M. documented the resident had increased anger/agitation, tried to leave the facility but did not know where he/she was going. The resident was running over other residents and staff with his/her wheelchair.

Nursing notes dated 5/3/15 at 1:21 P.M., documented the resident wandered in the halls in his/her wheelchair.

Nursing note dated 5/4/15 at 3:44 A.M. recorded the resident was up in the evening exit seeking.

Nursing note dated 6/4/15 at 4:04 P.M. documented the resident was very anxious and staff administered a PRN (as needed) medication at 3:30 P.M. The resident continued to roll his/her wheelchair up to different doors trying to open doors. One door had a key left in the lock and the resident received a triangle skin tear to the right inner skin fold between first and second finger.

Nursing note dated 6/13/2015 at 1:57 P.M. documented at 7:30 A.M. night staff reported the resident was outside on the patio behind the assisted living. Nursing staff went out and brought the resident back inside. Only one pager responded and the staff did not hear the door alarm.

The facility investigation documented the pagers were not sounding due to low batteries. Staff checked the door alarm sound and replaced batteries in all pagers.

Nursing note dated 6/17/15 at 11:57 A.M. the

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resident continued to frequent the assisted living unit in search of a way to leave.

Nursing note dated 6/25/15 at 5:48 P.M. documented the resident had been exit seeking all morning. Staff administered PRN antianxiety medication for anxious behavior. The resident exited the door on D-hall without staff assistance. Nursing staff brought the resident back inside. The resident continued wandering nonstop into different rooms and unable to slow down and nursing would continue to monitor the resident closely.

Review of the facility investigation dated 6/25/15 documented staff observed the resident exit seeking on D-hall five minutes prior his/her elopement. Review of the door monitoring log documented the D-hall door activated at 7:42 A.M. and was reset at 7:49 A.M. The facility investigations included witness statements as follows:
A witness statement from direct care staff M reported he/she attempted to redirect the resident from the exit, then left the resident and went to inform the charge nurses.
A witness statement from direct care staff N reported possibly hearing a door alarm; however, no page came through to alert staff of an open exterior door. Direct care staff N continued with another resident and when finished went to the nursing station, still hearing an alarm. Direct care staff N identified the D-hall door alarming, opened the door, and found the resident in his/her wheelchair outside in the staff parking lot unattended.
A witness statement from licensed nursing staff H recorded the resident left the building without a staff escort and staff observed the resident

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approximately 5 minutes prior to the elopement. A witness statement from direct care staff T reported he/she did not hear to the alarm sounding until he/she got down the D-hall.

The investigation lacked evidence staff checked and ensured the pager system alerted all staff with the door alarm system.

Nursing note dated 6/25/15 at 10:50 P.M. (not sure AM or PM) documented staff placed the resident on 15-minute checks. During an interview on 7/24/15 at 2:45 P.M. administrative nursing staff D reported the resident had not been on 15-minute checks. The facility provided hourly elopement location sheets for the resident. The facility lacked documentation of any 15-minute checks.

Nursing note dated 6/26/15 at 8:04 P.M. documented the resident wandering continuously and attempted to go out the assisted living door, but was noticed by staff before he/she could set off alarm.

Nursing notes on 6/27/15 at 3:24 P.M. recorded the resident continuously traveled up and down hallways pushing at door exits with nonstop exit seeking. The resident always closed the door after getting past the doorway so others cannot see him/her.

A social service note dated 7/22/2015 at 10:32 A.M. the resident wheeled his/her wheelchair all through the home on a daily basis and all throughout the day continuously going to the exit doors. The staff helped him and attempt to turn him around and stay inside the building.

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Observation on 7/16/15 at 10:57 A.M. the resident propelled him/herself towards the assisting living, knocked on the door and attempted to push it open. At 10:59 A.M. the resident propelled in the wheelchair away from the assisted living door. At 11:00 A.M. the resident propelled up to the surveyor and asked, " How do you get out of this place? I want to get out of here and get out there on the floor. " He then propelled self towards the windows. At 11:05 A.M. the resident propelled towards the assisted living doors and staff redirected the resident to the lobby area.

Observation tour of the building exit door alarms on 7/24/15 at 9:30 A.M. to 9:45 A.M. revealed the following doors with alarms not working properly:
9:35 A.M., D-wing door activates when pushed, after approximately. 15 seconds door opens and the test report ?alerts the D-wing door activated. Staff had to reset the alarm with code to silence the alarm. The door alarm continues to sound after closed.
9:43 A.M., C-wing door stuck and required staff to pound on the door several times before it would alarm.
9:45 A.M., B-wing door with double lock and key to exit because of stairs, alarmed okay.

During the observation of the door alarms, administrative nursing staff D reported all doors that exit outside the building alarm to all the pagers at the same time. The pagers designate which door alarms by a universal transmit.

From 6/11/15 through 7/24/15 staff failed to check all door alarms per the facility door alarm log.

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Additionally on the logs, the staff made the following notations:
On 7/15/15 C-hall door not working properly
On 7/17/15 at 9 A.M., C-hall door did not alarm door or pager, maintenance and information technology notified.
On 7/18/15 C-hall door did not alarm, or pager, maintenance and information technology aware.
On 7/19/15 at 11:55 A.M. " C-hall door will not open in 15 seconds. Will not open unless code put in. Alarm goes off if left open extended period and resets without entering code. Called information technology and left message to notify them the dining room door had to be reset to alarm.

Observation on 11:05 A.M. administrative nursing staff D activated the second assisted living door with the main assisted living door closed. The overhead sounding door alarm was not heard in the long-term care unit.

Observation on 7/24/15 at 11:18 A.M. revealed the resident propelled in the wheelchair toward the assisted living door, opened the door, and entered into the assisted living. At 11:20 A.M. direct care staff S stopped the resident as he/she was shutting the assisted living door, took the resident to the dining room table.

Observation on 7/24/15 at 4:00 P.M., the distance from the Assisted living 2 door patio to the highway, was 51 surveyor steps, an approximate 26-inch stride equaled approximately 110 feet. The speed limit on the highway coming into town is 55 miles per hour and goes to 35 miles per hour by the assisted living facility.

On 7/24/15 at 4:20 P.M., observation revealed

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staff redirected the resident from the assisted living hallway door.

On 7/24/15 at 5:15 P.M., the resident actively propelled in his/her wheelchair around the dining room and the lobby.

During an interview on 7/16/15 at 11:05 A.M. administrative nursing staff D revealed the resident ' s elopement on 6/13/15 happened at a busy time of the morning and the staff did not hear the alarm go off. He/she revealed the alarm board documented that it sounded and that it rang to the pagers but the pagers did not have an audible sound.

On 7/24/15 at 11:05 A.M. licensed nursing staff J reported opening any exit door alerts all staff pagers.

On 7/24/15 at 11:57 A.M. information technology staff Y reported the computer system at the nursing station can check the status of the door alarms and if a door alarm battery or call light battery was low, can be replaced. Information technology staff Y reported he/she checked the computer every week on Monday morning.

On 7/24/15 at 12:00 P.M. direct care staff R reported the resident wandered frequently in the assisted living and did not know the door reset code. Direct care staff R reported any exit door that opened set off all pagers and staff reset the door at the keypad.

On 7/24/15 at 12:07 P.M. Housekeeping/maintenance staff X reported the facility lacked a policy for replacement of pager batteries.

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On 7/24/15 at 12:15 P.M. direct care staff Q revealed the resident was an exit seeker. Direct care staff Q reported there was no way to check the batteries in the pager. If staff was not continuously getting pages, we know the battery needs changed.

On 7/24/15 at 12:42 P.M. licensed nursing staff I reported the nurses do elopement checks on the hour for all residents assessed at risk for elopement. Licensed nursing staff I revealed the morning of 6/13/15 another resident was at the door in the dining room wanting out when a staff member came in and said the resident was outside. The resident was in his/her wheelchair right off the patio. The pager did not alarm for the open door or when the code was entered, the pager did not show the reset. After staff brought the resident into the building, batteries in the pagers were changed. Licensed nursing staff I revealed he/she did not know how often to change the pager batteries. The resident traveled around and sometimes will turn around and come back. Nursing staff chased the resident around from door to door that day and kept a good eye on him/her all day.

On 7/24/15 at 12:55 P.M. direct care staff P reported on 6/13/15 at approximately 7:15 he/she left his/her home for the 5-minute drive to the facility. Direct care staff P reported when he/she came out of the building, he/she observed the resident in his/her wheelchair off the assisted living patio concrete, stuck in the mud. Direct care staff P reported he/she could not hear the alarm until getting close to the door. Staff carried pagers that alarm all the time. Direct care staff P revealed the resident was very active and exits

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seeks daily. At night, the resident goes door-to-door exit seeking. Staff checked for the resident about every 15-minute and had found him in at times the evening on the couch in the assisted living. The nurses do the hourly check of the resident ' s location.

On 7/24/15 at 2:00 P.M. direct care staff S reported staff monitored the resident and he/she tried to open the doors and heads toward the assisted living. Direct care staff S reported all the pagers sound at the same time with the door alarm. Direct care staff S revealed the charge nurse records the hourly monitoring of the resident and when the batteries get low, nursing staff change them.

On 7/24/15 at 2:35 P.M. direct care staff O reported the resident was a fall risk, an exit seeker, however the direct care staff frequently check the resident and the nurse documents the hourly checks. The staff did not perform 15-minute checks on the resident. Direct care staff O reported when working the morning of 6/13/15, the door alarm did not come to the pagers.

On 7/24/15 at 3:15 P.M. licensed nursing staff H reported seeing the resident around 6:45 A.M. on 6/13/15. The resident moves around in his/her wheelchair from door to door and in the dining room. The resident did so much exit seeking, staff constantly monitored the resident. The nurses document hourly checks of the resident. When an exit door opens all pagers alert at the same time. Staff recently found the resident out of his/her wheelchair on the floor crawling. The resident had personal alarms and when staff heard the alarm, they run to assist.

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Review of the facility safety policy lacked evidence to direct staff of routine maintenance of the pagers for the call system.

The facility lacked a policy to direct staff in the testing of staff call pagers.

The facility provided a policy Elopement Risk Assessment and Safety dated 9/11/14, directed all staff were responsible for monitoring residents, including those at risk for elopement.

On 7/24/15 at 3:44 P.M. the facility was notified of immediate jeopardy.

The facility failed to provide supervision to prevent the resident from leaving the facility unattended without staff knowledge.

This deficient practice placed this cognitively impaired resident at risk for elopement risk, in immediate jeopardy.

The facility abated the immediate jeopardy on 7/31/15 when all staff were inserviced when the facility:

1. Appropriately staffed the assisted living with staff assignment sheet to reflect caregiver assigned to the area. The caregiver would carry an appropriate pager to this area, answer all call lights, monitor resident safety, and respond to all door alarms. This was completed by 7/24/15.
2. All pagers will be checked at beginning of each shift by the Charge Nurse. This will be completed by sending a test page from the Home Free System. Charge Nurse will ensure each pager that is assigned received a page. Charge

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| F 323 | Continued From page 12<br>Nurse will document on the new form created for testing pagers. This document will be titled " Pager Assignment/Test Sheet " form. This will be completed by 7/24/15.<br>3. Door to enter Assisted Living will be removed to lessen the sound barrier of external door alarms. Motion sensor will be placed temporarily on entry to Assisted Living. This will notify staff of any person entering or exiting the Assisted Living hallway. This will be completed by 7/24/15.<br>4. 4. On 7/27/15 the Administrator, director of nursing and information technology personnel will research an updated wander guard system or other type of system that is compatible with current alarm/call light system for a more permanent solution.<br>5. 5. Train current staff on duty of updated changes. Create and read a sign for staff working throughout the weekend. On 7/27/15 director of nursing and quality assurance nurse will hold training huddles each shift for remaining staff. Training to be completed by 7/31/15.<br><br>The deficient practice remains at the scope and severity of a D | F 323 | | |